DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 6

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
SSA Section 1902(a)(13)(A), 42 CFR 447.250(a) & (b) 42 CFR 447.253(b) to (g)

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 13,500K
b. FFY 2002 $ 40,100K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
i, ii and 1-57 of Attachment 4.19-D .....

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
i, ii and 1-56 of Attachment 4.19-D

10. SUBJECT OF AMENDMENT:
Nursing home rate updates

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED: Robert M Blain

12. SIGNATURE OF STATE AGENCY OFFICIAL: Peggy B Handrich

13. TYPED NAME: Peggy B. Handrich

14. TITLE: Administrator, Division of Health Care Financing

15. DATE SUBMITTED: September 28, 2001

16. RETURN TO:
Peggy B. Handrich
Administrator
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9-28-01

18. DATE APPROVED: 5/13/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL: Lisa Ann Mercado

21. TYPED NAME: Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
SEP 28 2001
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FORM HCFA-179 (07-92)

Instructions on Back

STATE OF WISCONSIN

DEPARTMENT OF HEALTH AND FAMILY SERVICES
WISCONSIN MEDICAID PROGRAM

METHODS OF IMPLEMENTATION FOR WISCONSIN MEDICAID NURSING HOME PAYMENT RATES
FOR THE PERIOD JULY 1, 2001 THROUGH JUNE 30, 2002

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SECTION 1.000 INTRODUCTION

1.110 General Purpose

The purpose of the Wisconsin Medicaid Methods of Implementation for Medicaid Nursing Home Payment Rates is to ensure that nursing homes, including nursing facilities (NF), and intermediate care facilities for the mentally retarded (ICF-MR), are paid appropriately for care provided to Medicaid residents in a cost-efficient fashion.

Wisconsin nursing homes participating in Wisconsin Medicaid are paid by a prospective rate-setting methodology as stipulated in s. 49.45(6m), Wis. Stats. This methodology must meet federal standards and is established in the Methods issued annually by the Wisconsin Department of Health and Family Services, hereafter known as the Department. Within the Department, the Division of Health Care Financing (DHCF) has primary responsibility for establishing nursing home payment rates.

The Department shall develop such administrative policies and procedures as are necessary and proper to implement the provisions outlined in the Methods. This information shall be communicated to the nursing home industry as necessary, such as through program memoranda, provider handbooks, and Medicaid Updates. Such policies and procedures are generally intended to apply to usual and customary situations and are not necessarily applicable to special situations and circumstances. Any questions regarding specific circumstances should be referred to the Department.

It should be noted that the Department develops standardized calculation worksheets for the computation of payment rates under the Methods. These worksheets are an administrative tool and are generally intended to apply only to usual and customary situations.

1.115 Further Information

For further information, contact:

Nursing Home Section
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

Individual nursing homes should contact their district Medicaid auditor for specific questions on their payment rates.

1.120 Basis of the Nursing Home Payment Rates

Allowable payment levels were determined by the Department through examination of costs actually incurred by a sample of nursing homes in Wisconsin. Appropriate adjustments for actual and anticipated inflation levels were taken into account in projecting costs. One provision in these Methods helps assure that necessary and appropriate care continues to be provided by facilities which may not be economically and efficiently operated and which face unique fiscal circumstances. The Nursing Home Appeals Board helps ensure cost-effective operations and yet recognize exceptional circumstances, if warranted.

The Nursing Home Appeals Board is available for redress in the event a facility has extraordinary fiscal circumstances, as defined by statute 49.45(6m)(e) shown below.

49.45(6m)(e) The department shall establish an appeals mechanism within the department to review petitions from facilities providing skilled, intermediate, limited, personal or residential care or providing care for the mentally retarded for modifications to any payment under this subsection. The department may, upon the presentation of facts, modify a payment if demonstrated substantial inequities exist for the period appealed. Upon review of the department's decision the secretary may grant the modifications, which may exceed maximum payment levels allowed under this subsection but may not exceed federal maximum reimbursement levels. The department shall develop specific criteria and standards for granting payment modifications, and shall take into account the following, without limitation because of enumeration, in reviewing petitions for modification:

1. The efficiency and effectiveness of the facility if compared with facilities providing similar services and if valid cost variations are considered.
2. The effect of rate modifications upon compliance with federal regulations authorized under 42 USC1396 to 1396p.
3. The need for additional revenue to correct licensure and certification deficiencies.
4. The relationship between total revenue and total costs for all patients.
5. The existence and effectiveness of specialized programs for the chronically mentally ill or developmentally disabled.
6. Exceptional patient needs.
7. Demonstrated experience in providing high quality patient care.

1.130 Authority and Interpretation of 2001-2002 Methods
These Methods will determine payment for services provided during the twelve-month time period of July 1, 2001, through June 30, 2002, unless otherwise modified by legislative action, or federal or court direction. A new rate period begins with services rendered on or after July 1, 2002.

1.131 Severability
The provisions of the Methods of Implementation for the Medicaid Nursing Home Payment Rates are to be considered separate and severable.

1.132 Effective Period of Payment Rates
Rates shall be implemented on or after July 1, 2001, unless otherwise specified. Rates issued after July 1, 2001, shall be approved retroactively to July 1, 2001. However, rates may be approved effective on a later date under the provisions of Section 4.000 Rate Adjustments and Recalculations of these Methods.

1.133 Authority of 2002-2003 Methods
Applicable nursing home payment rates for services rendered on or after July 1, 2002, will be governed by the provisions of a separate, new 2002-2003 Methods, even if the 2002-2003 Methods are issued subsequent to July 1, 2002. Reimbursement rates established under one Methods will apply only to that reimbursement period.

1.134 Recoupment of Overpayment
Upon a rate decrease for any purpose, any excess payments for previously provided services shall be recovered from the provider. The amount to be recovered shall be determined by the Department or its fiscal agent. The amount shall be recovered within a recovery period not to exceed 60 days. Requests for a recovery period should be submitted to the fiscal agent.

As a standard procedure, the Department will recover the recovery amount by deducting, from each current remittance to the provider, a fixed percentage of each remittance. The Department shall establish the fixed percentage. If the total amount is not fully recovered within the first 30 days of the recovery period, then the Department may establish larger repayment installments in order to assure the total amount is fully recovered by the end of the 60 day recovery period.

If enough Accounts Receivable shall not be generated by the fiscal intermediary to recover 100% of the funds within 60 days, a lump sum payment shall be made to the Department for the difference. In addition, if the Department's fiscal agent cannot determine the amount of the recovery, the amount will be determined by the Department. In these situations, the recovery amount shall also be recovered within 60 days and may either be deducted from current remittances to the provider or repaid by the provider to the Department's fiscal agent.

1.140 Litigation
The State has been or may be involved in litigation concerning the validity or application of provisions contained in this Methods or provisions of previous Methods. Medicaid payments resulting from entry of any court order may be rescinded or recouped, in whole or in part, by the Department if that court order is subsequently vacated, reversed or otherwise modified, or if the Department ultimately prevails in litigation. When recoupment occurs, recoupment will be made from all facilities affected by the issuance of the court order, whether or not such facilities were parties to the litigation. If any provision of this Methods is properly and legally modified or overturned, the remaining provisions of this Methods are still valid.

1.160 Medicaid Participation Requirements
All nursing homes participating in the Medicaid program must meet established certification requirements, adopt a uniform accounting system, file a cost report, and disclose the financial and other information necessary for verification of the services provided and costs incurred. The Department will specify the time periods and forms used for those purposes.

1.170 Cost and Survey Reporting Requirements

1.171 Cost Reporting
All certified nursing home providers must annually submit a "Medicaid Nursing Home Cost Report" for the period of the home's fiscal year. Under special circumstances, the Department may require or allow a provider to submit a cost report for an alternative period of time. A standardized cost reporting form and related instruction booklet, which include detailed policies and instructions for cost reporting, are provided by the Department. This cost report and the related cost report instruction booklet along with policies adopted by the Department, are an integral and important part in determining payment rates. Additionally, the Department may require providers to submit supplemental information beyond that which is required in the cost report form. Supplemental information

concerning related entities shall be made available on request. The intent of cost reporting is to identify the costs incurred by the nursing home provider to be used in the application of the Medicaid payment policies and methodology.

1.171(b) All Certified Nursing Home Providers Must Submit
An annual survey of nursing homes on report forms and/or in an electronic format that meets the Department's specifications. The Annual Survey of Nursing Homes report form options and instructions are provided by the Department. Reports must be based on the calendar year or the portion of the calendar year during which the nursing home was in operation.

1.172 Signature
If the cost report or annual survey is prepared by a party other than the nursing home owner or a nursing home employee, it must be signed by both the preparer and the owner/employee.

1.173 Timely Submission
The completed cost report is due to the Department within three months after the end of the cost reporting period unless the Department allows additional time. The due date of supplemental information, including responses to DHCF questions, will depend on the complexity and need for the information being required. The due dates for cost reports for the Nursing Home Appeals Board shall be established by the Board and may be less than three months. The Department shall establish and implement policies to withhold payment to a provider, or decrease or freeze payment rates, if a provider does not submit cost reports and required supplemental information and responses to DHCF questions by the due dates.

The completed Annual Survey of Nursing Homes is due to the Department by February 1 of each year, unless the Department allows a maximum 28 day extension. The Department shall establish and implement policies to withhold payment to a provider, or decrease or freeze payment rates, if a provider does not submit annual survey forms and respond to the Department by the due date.

Failure to pay the Occupied Bed Assessment in a timely fashion will also cause the Department to withhold payment to a provider.

Facilities that do not meet the requirements of this section will have payment rates reduced according to the following schedule:

25% for cost reports, supplemental information, occupied bed assessments and/or annual surveys between 1 and 30 days overdue.
50% for cost reports, supplemental information, occupied bed assessments and/or annual surveys between 31 and 60 days overdue.
75% for cost reports, supplemental information, occupied bed assessments and/or annual surveys between 61 and 90 days overdue.
100% for cost reports, supplemental information, occupied bed assessments and/or annual surveys more than 90 days overdue.

The number of days overdue shall be measured from the original due date, without extension, of the cost report, supplemental information, occupied bed assessment and/or nursing home survey.

The rates will be retroactively restored once the cost report, supplemental information, occupied bed assessment and/or nursing home survey is submitted to the Department.

1.174 Records Retention
Providers must retain all financial records, statistical records and worksheets to support their cost report and supplemental information for a period of five years. (Reference: HFS 105.02, Wis. Adm. Code). Records and worksheets must be accurate and in sufficient detail to substantiate the reported financial and statistical data. These records must be made available to the Department or the United States Department of Health and Human Services within a reasonable time from the date of request and at a location within Wisconsin unless alternative arrangements can be made with the Department. Failure to adequately support reported amounts may result in retroactive reductions of payment rates and recoveries of monies paid for services.

1.175 Change of Ownership
Upon change of ownership of a nursing home operation, the prior owner is required to submit a cost report for the fiscal period prior to the ownership change unless the Department determines the cost report is not needed. The prior owner's failure to submit such a cost report may limit the new provider's payment rates. IT IS IMPORTANT THAT THE NEW OWNER ASSURE THAT THE PRIOR OWNER SUBMITS THE COST REPORT. Also see Sections 4.200 through 4.230.

1.176 Combined Cost Report for Multiple Providers
A separate cost report is to be submitted by each separately certified nursing home provider. Nevertheless, the Department may allow or require two or more separately certified providers to submit a single combined cost report in the following circumstances:

1. Multiple Certified Nursing Homes. A combined cost report may be allowed or required for two or more separately certified nursing homes which are located on the same or contiguous property and which are fully owned by the same corporation, governmental unit or group of individuals.

2. Small Nursing Homes. A combined cost report may be allowed or required for two or more separately certified nursing homes when each has a capacity of less than 25 licensed beds and when all are fully owned by the same corporation, governmental unit or group of individuals.

3. Distinct Part ICF-MRs. A provider operating in conjunction with a distinct part ICF-MR provider, as defined in Section 1.311, shall be required to submit a combined cost report for both providers.

4. Distinct Part IMDs. A provider operating in conjunction with a distinct part institution for mental disease (distinct part IMD) provider, as defined in Section 1.312, shall submit a combined cost report. However, the Department may require separate cost reports depending on individual circumstances.

The Department shall not allow a combined cost report for a facility if the Department estimates that payment rates which are determined from such a report are likely to result in payments which are substantially in excess of the amount which would be paid if separate cost reports were submitted. The Department shall not allow a combined cost report if a facility's rates cannot be readily or appropriately calculated based on such a report.

1.200 ALLOWABLE EXPENSES

1.210 Patient Care Related Expenses

Only expenses incurred by the nursing home related to nursing home patient care shall be allowable for payment. Expenses related to patient care include all necessary and proper expenses which are appropriate in developing and maintaining the operation of nursing home facilities and services. Necessary and proper expenses are usually expenses incurred by a reasonably prudent buyer which are common and accepted occurrences in the operation of a nursing home.

1.215 Sanctions

Allowable expenses do not include forfeitures, civil money penalties or fines assessed under Wisconsin Statutes, Administrative Rules, Federal Regulations or local ordinances.

1.220 Bad Debts

Bad debts and charity and courtesy allowances applicable to any patient shall not be allowable expenses.

1.230 Prudent Buyer

The prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, but also seeks to economize by minimizing cost. Any alert and cost-conscious buyer seeks such advantages, and it is expected that Medicaid providers of services will also seek them.

The Department may employ various means for detecting and investigating situations in which costs seem excessive. These techniques may include, but are not limited to, comparing the prices paid by providers to the prices paid for similar items or services by comparable purchasers; spot-checking; and querying providers about direct and indirect discounts. In those cases where the Department notes that a provider pays substantially more than the going price for a supply or service in the absence of clear justification for the premium, the Department will exclude excess costs in determining allowable costs for payment rates.

1.240 Approvals under the State's Resource Allocation Program: Long-Term Care

Unless otherwise specified in this Methods, payment shall not be provided for expenses related to capital projects or changes in service which were not approved or for which notice was not given (if required) under Section 1122 of the Social Security Act or Chapter 150, Wis. Stats.

The Department shall retroactively reverse or negate the effect of rate adjustments due to a Resource Allocation Program project if the facilities did not complete the projects.

1.241 Workers Compensation

By Statute, nursing homes are required to provide Workers Compensation (WC) insurance for their employees. The Wisconsin Compensation Rating Bureau (WCRB) has the authority to establish rates for WC insurance. The allowed WC cost will be the lesser of the calculated amounts obtained from the WCRB WC policy for a given nursing home or allowable cost of a self insurance plan.

WC expenses may need to be accrued on an estimated basis since subsequent audit may result in an adjustment to the Experience Modification Factor (EMF) resulting in additional costs or refunds for the cost reporting period. Allowed WC expense will be the

amount accrued and paid within 75 days of the end of the cost report period. Any changes to previously estimated Workers Compensation amounts that result in additional costs or refunds shall be reported as an addition or reduction of WC expense in the cost reporting period that they become known.

1.245 Legal and Other Professional Fees

Under the following circumstances, legal and other professional fees incurred by a provider are not related to patient care and are thus not allowable expenses:

1. The provider (or an organization of which a provider is a member) incurs the fees for the prosecution or defense or potential prosecution or defense of any administrative appeal or judicial suit which results from any reimbursement action taken by a state or federal agency administering Title XVIII or Medicaid programs.

2. The provider (or an organization of which a provider is a member) incurs the fees in an administrative appeal or judicial suit which results from any action by the state agency that administers licensing and certification requirements, unless the administrative law judge in the administrative appeal awards fees in a motion brought under Section 1.2455.

3. The provider incurs fees defending an owner or an employee in any personal matter or in any criminal investigation or prosecution.

4. The provider incurs the fees in any other remedial process pursued prior to the filing of an appeal under chs. 50 or 227, Wis. Stats., or a judicial suit.

5. Other fees not related to patient care.

1.2455 Award of Fees

The treatment of legal fees and other professional fees incurred in a provider's administrative appeal of any action by a state agency that administers licensing and certification requirements shall be as follows:

1. Upon resolution of any such appeal, the provider or the state agency may submit a motion for award of fees to the administrative law judge. The judge shall award fees if the judge determines that the moving party is the "prevailing party," unless the judge determines that the other party had a reasonable basis in law and fact for taking its position or that special circumstances exist that would make an award unjust. The judge shall determine the prevailing party and the amount of the award pursuant to ss. 227.485(4) and 814.245(5), Stats., except that the amount of the award shall not include any fees associated with preparing, submitting or litigating the motion for fees. The judge's decision is not subject to judicial review.

2. If the fees are awarded to the provider under this section, the amount awarded will be treated as an allowable expense in the cost report year or years in which the fees were incurred, to the extent the amount does not exceed the Administrative and General cost center maximum limitation under Section 3.250 of the Methods. If the fees are awarded to the Department in its role as state licensing or certification agency, the amount awarded will be deducted from the provider's otherwise allowable costs in the Administrative and General cost center for the cost report year or years in which the fees were incurred.

3. Section 227.485, Stats., is intended to allow an administrative law judge to award costs associated with a hearing to the prevailing party in the proceeding, upon motion of that party, but it only allows such awards for individuals, small non-profit corporations, or small businesses. Providers who are individuals, small non-profit corporations or small businesses, and who pursue costs under s. 227.485, Stats., shall not be entitled to, in addition, pursue costs under the provisions of this state plan.

1.246 Accruals of Paid Time Off

The Department will not recognize the accruals of expenses for paid time off. It will recognize only the cost of paid time off (i.e. vacations, sick leave, etc.) which has been paid during the cost reporting period.

1.247 On-Premise Time Off

On-premise paid time off (i.e., break time, paid meal time, etc.) should be reported as productive time and wages.

1.248 Self-Insurance Costs

The allowable expense for self-insurance plans is the actual claims paid during the cost reporting period. At the facility's option, accrual of pending claims may be made to the extent that such claims are paid within 75 days of the close of the cost reporting period. Such accrued claims may not be expensed in the following year's cost report. If a facility's self-insurance fund is managed by an independent (non-related) trustee, the fee paid to the trustee may be included in allowable self-insurance costs. If actuarial determinations are performed by an independent (non-related, non-employee) actuary, the fee paid to the actuary may be included in allowable self-insurance costs. Allowable self-insurance costs may also include the premium costs of re-insurance ("stop-loss") policies purchased from an unrelated company and any costs to administer the self insurance plan. Allowable costs shall then be reduced for investment income. In order for investment income to remain in the self insurance allowable cost determination, it must be

separately identified and accounted for as related to the self insurance plan. If not separately identified, investment income will be treated according to Section 1.270 and/or Section 3.526. Any proceeds from these policies will be offset against the claims paid during the cost reporting period of receipt.

For purposes of implementing this section and payment plan, the terms self-insurance and self-funded are synonymous. Self-insurance is a means where a provider, either directly or indirectly or through a separate entity, trust or fund, undertakes the ultimate risk by assuming the actual liability for insurance costs as defined in this section. The creation of a separate entity, trust or fund for insurance purposes does not eliminate the provider's ultimate insurance risk or liability. Payment of insurance premiums to an insurance company, in the business of offering insurance to the general public, where such premiums are the final liability of the provider regardless of the actual cost incurred by the insurance company does not constitute self-insurance.

1.249 Provider Assessments or Provider Specific Taxes

Reimbursable expenses under these Methods will not include any cost attributable to taxes or assessments on occupied beds imposed by this State solely with respect to nursing homes or ICF-MRs.

1.250 Costs from Related Parties and Related Organizations

1.251 Allowable Related Party Costs

A nursing home may incur expenses for services, facilities and supplies furnished by organizations related to the nursing home by common ownership or control. In lieu of such expenses incurred by the nursing home, allowable expenses for payment may include the expenses incurred by the related organization for the furnished items. Allowable expenses must not exceed the lesser of:

a. The expense incurred by the related organization for the services, facilities or supplies which the related party furnished to the nursing home, or

b. The price of comparable services, facilities or supplies that could be purchased elsewhere.

The purpose of this principle is to avoid the payment of a profit factor to the nursing home through the related organization, and also to avoid payment of artificially inflated expenses which may be generated from less than "arm's length" bargaining.

1.252 Definitions for Related Parties

A "related party" or "related organization" is an individual or organization related to a nursing home by either common ownership or control.

"Related to the nursing home" means that the nursing home, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities or supplies.

"Common ownership" exists when an individual or individuals possess significant ownership or equity in the nursing home and in the institution or organization serving the nursing home.

"Control" exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

"Immediate family relationships" include husband/wife, natural parent, child, sibling, adoptive child and adoptive parent, step-parent, step-child, step-sibling, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent and grandchild.

1.253 Determination of Relatedness

In determining whether a nursing home is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. The existence of an immediate family relationship will create a rebuttable presumption of relatedness.

a. "Related by Common Ownership." A determination as to whether an individual(s) or organization possesses significant ownership or equity in the nursing home organization and the supplying organization, so as to consider the organizations related by common ownership, should be made on the basis of the facts and circumstances in each case. This principle applies whether the nursing home or the supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of a nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization (for example, a reversionary interest provided for in the articles of incorporation of a nonprofit corporation).

b. "Related by Control." The term "control" includes any kind of control which is exercisable, regardless of legal enforceability. It is the reality of the control which is decisive, not its form or mode of its exercise. The facts and circumstances in each case must

be examined to ascertain whether legal or effective control does exist. Since a determination reached in a specific case represents a conclusion based on the entire body of facts and circumstances involved, such determination should not be used as a precedent in other cases unless the facts and circumstances are substantially the same.

c. "Exception." An exception is provided to the general rule applicable to related organizations. The exception is intended to cover situations where large quantities of goods and services are furnished to the general public and only incidentally are furnished to a nursing home by a related organization. The exception applies if the provider demonstrates to the satisfaction of the Department that the following criteria are met:

1. The supplying organization is a bona fide separate organization.

2. A substantial part of the supplying organization's business activity as engaged with the nursing home is transacted with other organizations not related to the nursing home and the supplier by common ownership or control AND there is an open, competitive market for the type of services, supplies or facilities furnished by the organization.

3. The services, supplies or facilities are those which commonly are obtained by nursing homes from other organizations and are not a basic element of patient care ordinarily furnished directly to patients in nursing home operations.

4. The charge to the nursing home is in line with the charge for such services, supplies or facilities in the open, competitive market, and no more than the charge made by the organization, under comparable circumstances, to other customers for such services, supplies or facilities.

If all the above conditions are met, the charge by the related supplier to the nursing home for such services, supplies or facilities shall be an allowed expense for payment.

1.254 Documentation
The nursing home must make available to the Department adequate documentation to support the costs incurred by the related organization, including access to the related organization's books and records concerning supplies and services furnished to the nursing home. Such documentation must include an identification of the organization's total costs, and the basis of allocation of direct and indirect costs to the nursing home and to other entities served.

1.255 Medicare Influence
Generally, the Department will refer to the Medicare Program's guidelines and interpretations when examining payment issues arising out of costs to related organizations.

1.256 Related Party Compensation
Any form of compensation to owners or related parties which is included in the payment rate must be reasonable and necessary. "Reasonable" means that the compensation should not exceed what would be paid by other nursing homes or the home in question for similar services. "Necessary" means that the services are required and commonly performed in other nursing homes and that, if the services were not performed by the owner or related individual, another person would have to be employed or contracted to perform them. Workers, who are members of the religious order (or society) which owns the nursing home, are to be treated as related parties under this section.

1.260 Employee Compensation
Any form of compensation which is included in the payment rate must be reasonable and necessary. "Reasonable" means that the compensation should not exceed what would be paid by other nursing homes or the home in question for similar services. "Necessary" means that the services are required and commonly performed in other nursing homes.

1.265 Out-of-State Travel
Out-of-state travel and related travel expenses shall not be allowed, except for travel expenses to and from the nursing home's home office. This provision shall not apply to travel within 100 miles of the Wisconsin border or to home office personnel with one or more nursing homes located outside the State of Wisconsin. Travel expenses shall include but not be limited to meals, lodging, transportation, and all training, seminar and convention fees and expenses associated with the out-of-state trip.

1.266 Definition of Investment Income
Investment income consists of the aggregate net amount from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss is not allowable.

1.270 Interest Expense on Working Capital Debt

Working capital loans are debts entered into by a provider to finance current operations until current cash flow allows payment of the debt. Such debts may carryover from a recent fiscal year to the current fiscal year. Only interest expense on operating working capital loans which are related to patient care shall be allowed to be included in the calculation of the administration and general allowance. The Department shall determine allowable expense and shall include the following adjustments.

1. Revenues from any invested funds shall be offset against working capital interest expense; such revenues remaining after the offset may be offset under Department policy in determining the property allowance per Section 3.500.

   a. Investment income earned by any home office, other corporate entity or organization, foundation or related party that has a purpose of furthering the goals and objectives of the nursing home or its related organizations, shall be offset against the nursing home's allowable interest expense. Long term interest expense and working capital interest expense shall be offset by investment income from all sources (including home office, other corporate entities or organizations, foundations and related parties). Offsets from these entities shall be applied after offsets to interest expense at the home office, other corporate entities or organizations, foundations and related parties are made. Offsets to the nursing home shall be allocated based on the home office or foundation acceptable allocation basis. The investment income offset shall first be applied to working capital interest expense and then to long term interest expense.

   b. Investment income generated to meet specific financial reserve requirements of the Office of Commissioner of Insurance or other regulatory agencies will be exempt from the income offset requirement.

2. Interest expense on borrowed funds which are not used for operating the nursing home shall not be allowable.

3. An amount will be disallowed from working capital interest expense by applying an 8.3% per annum interest factor to the following amounts from the base cost reporting period. This standard disallowance shall only be applied to interest expense which exceeds $.10 per adjusted patient day (after applying 1 and 2 above).

   a. Disallowed compensation;

   b. Disallowed expenses;

   c. Stockholder dividends and owners equity distributions during the base cost reporting period;

4. This adjustment (4) will only be applied to any interest expense which exceeds $.20 per adjusted patient day after applying adjustment 3 above. An amount will be disallowed from interest expense by applying 8.3% to the following amounts from the cost reporting periods which were used in calculating the June 30th payment rate for the three years prior to the current payment rate year.

   a. Disallowed compensation;

   b. Disallowed expenses;

   c. Stockholder dividends and equity distributions during the cost reporting periods.

5. Interest on debts to acquire plant assets, which is not reimbursed under the property allowance in Section 3.500, shall not be allowed as interest in the administrative component.

1.281 Therapy and Beauty and Barber Shop Spaces

Support service, fuel and utility, property tax, and property expenses which are indirectly allocated to therapy services and beauty and barber services, on the basis of the building area which those services use, shall be generally allowed in the calculation of the payment rate. If gross therapy revenues (physical, occupational, and speech) are less than $100,000 for the applicable cost reporting period, then space allocations will not be made. If gross therapy revenues (physical therapy, occupational therapy, and speech therapy) generated in nursing home therapy space attributable to non-nursing home residents equal 2% or more of total gross therapy revenues and/or if the nursing facility (or a related party as defined in Section 1.252) bills Medicare Part B for therapy generated in the nursing facility therapy space and the Medicare Part B revenues equal 10% or more of the total therapy revenues, then space allocations shall be made on a square footage basis. If the nursing home is subject to an allocation under the Medicare Part B criterion, then the non-nursing home resident allocation will be made if there are any non-nursing home resident therapy revenues. These qualifying criteria are based on the facility's cost reporting period for the payment rates.

1.282 Transportation

Revenues from transportation services shall be offset against transportation or administrative cost center expenses. In lieu of a revenue offset, expenses appropriately allocated by the nursing home to the revenue-generating transportation services may be offset against the cost center expenses.

1.290 Institutions for Mental Disease and Mentally Ill Nursing Home Residents

Sections 1.291 through 1.294 describe limitations on payments to institutions for mental disease and nursing homes for the care of mentally ill residents, as required by 1987 Act 399.

1.291 Limitation on Payment
Operating, capital and ancillary costs attributable to the care of 21 through 64 year old residents of an institution for mental disease are not allowable costs, except that costs for 21 year old residents are allowable if the resident resided in the institution for mental disease immediately prior to turning 21.

1.292 Limitation on IMD Patient Days
This section applies to IMDs and facilities declared to be at risk of being IMDs which agree to receive a permanent limitation on payments, pursuant to s. 46.266(1)(am), Wis. Stats. For these facilities, costs attributable to Medicaid patient days in excess of the patient day cap are not allowable costs. The patient day cap is determined as follows:

Patient day cap = 365*[A + (B-C)], where

A = The number of Medicaid eligible residents of the facility on the date that it is declared an IMD or the date that it is declared at risk of being an IMD.

B = The total licensed beds in the facility on the date that the facility agrees to receive the permanent limitation on payments.

C = The total residents of the facility on the date that it is declared an IMD or the date that it is declared at risk of being an IMD.

The patient day cap may be increased by 365 patient days for each resident who was not eligible for Medicaid on the date the facility was declared an IMD or at risk of being an IMD, but who becomes eligible at a later date.

1.294 Cap on Mentally Ill Nursing Home Residents
Pursuant to s.49.45(6j), Wis. Stats., the number of mentally ill Medicaid recipients in a nursing home determined by the Department to be at risk of being an IMD may not exceed the average population of mentally ill Medicaid recipients age 21 through 64 (excluding persons under 22 who were receiving Medicaid services in the facility prior to July 1, 1988, and continuously thereafter) in the nursing home during the period from January 1, 1987, through June 30, 1988. Costs attributable to mentally ill residents of the facility in excess of the average population are not allowable costs.

1.296 Hospice
If an NF contracts with a hospice to provide care for a terminally ill resident, costs attributable to care for that resident are not allowable costs.

For cost allocation purposes, hospice patient days shall be treated as any Medicaid patient days for allocating all but direct care costs. To allocate direct care costs:

a. A residential level of care shall be assigned to hospice patient days for persons who are permanent residents of the facility; and

b. A medical level of care as appropriate shall be assigned to hospice patient days for persons admitted for temporary stays.

1.300 GENERAL DEFINITIONS

1.301 Active Treatment
Active treatment for developmentally disabled and mentally ill nursing home residents means an ongoing, organized effort to help each resident attain his or her developmental capacity through the resident's regular participation, in accordance with an individualized plan, in a program of activities designed to enable the resident to attain the optimal physical, intellectual, social and vocational levels of functioning of which he or she is capable.

1.302 Base Cost Reporting Period
Payment rates shall be based upon information from cost reports for the provider's fiscal year ending in the calendar year prior to effective date of the payment rates per Section 1.132, except that the property tax allowance shall be based on the cost reporting periods described under Section 3.400. Payment rates may be based on alternative cost reporting periods acceptable to the Department, whenever allowed under the provisions of Section 4.000 of this Methods.

Expenses included in a reporting period are to be on the accrual basis of accounting, except where otherwise noted. For reimbursement purposes, the accrued expense must be paid within 180 days following the end of the reporting period. An expense disallowed under this section in any cost report period may not be claimed on a subsequent cost report. Specific exceptions to the 180 day rule may be granted by the Department for documented contractual arrangements such as receivership, property tax installment payments, and pension contributions; or expenses relating to audit of another provider group if the audit settlement indicates acceptance of these costs in writing. Note Section 1.248 for pending claims for self-insurance costs.

For 2001-2002 rates, the facilities' 2000 cost reports will be used to calculate payment rates. Exceptions to this may be for facilities in a start-up or phase-down period per Sections 4.300, 4.400, 4.500 and 4.600 as mentioned in Section 1.302.

1.303 Common Period
The common period to which expenses will be inflated or deflated is the twelve-month period preceding the payment rate year described in Section 1.314. For 2001-2002 payment rates, the common period covers the twelve months of July 2000 through June 2001.

1.304 Definition of Significant Changes in Licensed Bed Capacity
Unless otherwise stated in this Methods, a significant increase or decrease in licensed bed capacity is defined as the lesser of: (1) a change that is greater than or equal to 25.0% of the previously unrestricted use licensed beds or (2) 50 beds.

1.305 New Facilities
A new facility is defined as a nursing home newly beginning operation and not previously licensed as a nursing home. A change in ownership does not constitute a new facility. An existing operation, which becomes certified for the Medicaid Program, shall not be considered a new facility.

1.306 Replacement Beds and Facilities
A replacement is defined as the licensure and certification by a Medicaid provider of beds to take the place of beds closed or de-licensed by the same or a related provider. Total replacement means all beds under a provider's certification were replaced. The resulting licensed bed capacity of the provider may be considered a significant increase or decrease in licensed beds if the criteria of Section 1.304 are met.

1.307 Adjusted Patient Days
The term "adjusted patient days" means patient days, including therapeutic and hospitalization bed hold days, as reduced to recognize the 15% discount on the payment rate for bed hold days and other adjustments determined by the Department. For example, 1000 patient days, including 100 bed hold days, would be reduced by 15 days (i.e. 15% x 100) to 985 adjusted patient days.

1.308 Fringe Benefits
The term "fringe benefits" refers to general fringe benefits for staff as defined in detail by the Department in the Medicaid nursing home cost report form. Significant, unique benefits, as defined in the cost report form, are to be included as a salary or wage expense under this Methods and not as a fringe benefit expense. For facilities with special salary and wage payments to employees, such as bonuses, the Department shall classify such payments as salaries instead of fringe benefits.

1.309 Average Licensed Beds
The term "average licensed beds" means the average of the number of licensed beds of the facility on the last day of each month of the period for which the average is being determined. An average for a one-month period shall be the average of the daily number of licensed beds.

1.310 Significant Licensed Bed Days
A significant number of licensed bed days is the lesser of 4500 licensed bed days or 25.0% of the annualized bed days of the provider.

1.311 Distinct Part ICF-MR
A distinct part ICF-MR is a specific segment of a licensed NF facility which has been certified by the Department as a distinct part intermediate care facility for the mentally retarded.

1.312 Institution for Mental Disease (IMD)
An institution for mental disease (IMD) is an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services as determined by the Department or the federal Health Care Financing Administration. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental disease.

1.313 Restricted Use Beds
1. Restricted use beds are beds that exceed a nursing home's normal maximum bed capacity or are not in use due to remodeling. If a facility is remodeling a portion of the nursing home, and the beds will not be available until after the remodeling is complete, the beds are shown as restricted use beds. Beds may also be restricted use beds if they are transferred to a nursing home because of